Health and Medical Record/Release

IDENTIFICATION

Name ____ Birth Date ____________________

Address ____ Phone ____________________

City ____ State __________ Zip ____________

❐ Male ❐ Female Religion ______________________________

HEALTH HISTORY

Have you had any of the following conditions? Mark "past" or "now" or leave blank if never had.

_____ Asthma
_____ Hay Fever
_____ Sinus Trouble
_____ Ear Ache/Infection
_____ Ear Tubes
_____ Fainting Spells
_____ Tuberculosis
_____ Bedwetting
_____ Kidney Disease
_____ Constipation
_____ Frequent Diarrhea
_____ Severe Stomach Ache
_____ Diabetes
_____ Sleep Walking
_____ Epilepsy
_____ Rheumatic Fever
_____ Heart Trouble
_____ Glasses
_____ Contact Lenses
_____ Menstrual Problems

ALLERGIES OR ALLERGIC REACTIONS (Check if yes and tell what the symptoms are)

❐ Penicillin ____
❐ Other Medications (List): ____
❐ Bee Sting ____
❐ Food ____
❐ Poison Oak, Poison Ivy ____
❐ Other: List ____
____
____

PLEASE LIST ALL SERIOUS ILLNESSES OR OPERATIONS IN THE PAST FIVE YEARS

Operation or Illness	Date	Hospitalized? (yes/no)
____________________	____________	____________
____________________	____________	____________

PLEASE LIST ALL MEDICATIONS CURRENTLY BEING TAKEN

Medication	Number of Times a Day	Reason for Taking
________________	__________	____________________
________________	__________	____________________

IMMUNIZATION HISTORY (or attach copy of current immunization record)

Required immunizations must be determined locally. This is a record of dates of being immunized and most recent booster doses.

DTP Series __________ Booster __________

Polio (IPV) __________ Booster __________

MMR (measles/mumps/Rubella) ____________________

Tetanus Booster ____________________

Chicken Pox ____________________

DIET

❐Regular ❐Diabetic ❐Low Salt ❐Low Fat/Cholesterol

❐Other - Special Instructions ____

PHYSICAL ACTIVITY

Any restriction of activity for medical reasons? Explain: ______________________________

____

Any other type of health concerns which might be pertinent? ______________________________

____

Name: ______________________________

INFORM IN CASE OF ACCIDENT OR ILLNESS

Father/Guardian____ Phone (H) __________________________

Home Address ____ Cell: ______________________________

____

Work Address ____ Phone (W) __________________________

____

Mother/Guardian____ Phone (H) _______________________

Home Address ____ Cell: ______________________________

____

Work Address ____ Phone (W) __________________________

____

If not available, in emergency notify:

Name ________________________________ **OR** Name ________________________________

Address ______________________________ Address _____________________________

_____________________________________ _____________________________________

Phone (H) _____________ (W) _____________ Phone (H) ______________ (W) ____________

DOCTOR TO CONSULT IN CASE OF EMERGENCY

Name ____ Phone (______) _________________________

Address _____________________________________ City _________________________________

____ State ____________ Zip __________________

DO YOU HAVE Medical Insurance ❒ Yes ❒ No Number _________________ Type Coverage __________________

Company Name ____

Information above is correct to the best of my knowledge.

Date _____________________ Signed ____

Parent or Guardian

Parent's Authorization*—required for those less than 18 years of age. This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injection or surgery for my child.*

Parent/Guardian's Signature _______________________________

Date ____

Subscribed and sworn to before me this

_________ day of _________________________

____

Notary Public

My commission expires: ____________________